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St. Bartholomew's Hospital Journal,

FEBRUARY 14th, 1897.

"Æquam memento rebus in arduis
Servare mentem."—Horace, Book ii, Ode iii.

THAS been thought well that the ST. BARTHOLOMEW'S HOSPITAL JOURNAL should deal with a matter that is an every-day topic of conversation. What is a man's duty towards his hospital? Many consider that a man owes no duty towards his hospital beyond the payment of the regulation fees. Others maintain that he should subscribe to all the clubs of the hospital, become an active member of as many of them as he is physically able, join in every social movement set on foot by members of the hospital, and never be guilty of the, to them, unpardonable crime of pleading his professional work as an excuse for not attaining this high ideal.

Between these two extremes there are many intermediate views. The extremes may be wrong, but surely it cannot

be disputed that in signing his name as a student a man undertakes definite responsibility towards the hospital he has selected as his *alma mater*.

Had all men who have passed through our Hospital as students held themselves free from responsibility of this sort, and had they thought only of their own personal advancement, St. Bartholomew's would never have enjoyed the reputation it does. Hence men who qualify from Bart.'s now are reaping the value of the public spirit of their predecessors. In all fairness it must, then, be the duty of present Bart.'s men to preserve the reputation and credit of the Hospital, so that their successors may inherit with the name of "Bart.'s man" the same advantages which they have themselves enjoyed.

A man may fail in his duty either negatively or positively. He may go through his course thinking only of his own pleasure or advancement, and may in his whole connection with his hospital make no effort to add to its credit. On the other hand, he may be guilty of conduct which will bring actual discredit upon the school to which he is attached, or after leaving the hospital he may as a practitioner do harm to the reputation of the school he has left.

Thus we have three groups of men who fail in their duty,—those who do not interest themselves in the general welfare of the Hospital; those who, as students, bring discredit on their school; and those whose behaviour as practitioners causes the reputation of their training school to suffer.

Of the first class we have little to say. They, poor things, are perhaps not to blame. Their mentalizing power may be only just sufficient to carry them so far as the various examinations, and were they to devote any thought to the welfare of their hospital, they might occupy more time even than they do now in reaching their goal. We do not grudge them the undeserved reputation they obtain in the eyes of the world as "Bart.'s men." They doubtless need it, for though much literature may be compressed into their minds, their knowledge of the world is small, their capability of adapting themselves to varying circumstances less, and their tact a negligible quantity. With one more

remark we dismiss them. Strange as it may seem, these are the men most given to grumbling at the small amount of interest evidenced in their progress by the authorities, and the imperfections of their school. The second class is a large one, and at once divides itself into two subdivisions: those who, while doing all they can to support the prestige of the Hospital, are occasionally betrayed into actions which are the outcome rather of thoughtlessness than vice, and those who not only do nothing for, but actually detract from the Hospital credit. The former, we confess, are vastly more to our mind than the members of the second subdivision who err in regard to *both* portions of their duty.

Recently a man who may be regarded as a type of the first group of delinquents—the negative gentlemen—succeeded in distinguishing himself in the latter division of the active group. Letters from him appeared in the public press signed with his name *and* qualifications, and dated from the library of St. Bartholomew's Hospital, in which, aiming doubtless at inexpensive self-advertisement, he bragged of his connection with Bart.'s, expressed his opinion upon a matter of great importance to the Hospital, and enclosed a donation of one shilling to a public fund.

Now this gentleman is at perfect liberty to write to the public press as often as he likes, and to send shillings to any public fund he likes; but we would like to see his letter, his opinion, and his money dated from his own residence, and not from the library at Bart.'s.

Many in the outside world may be excused if they regard such a letter as emanating from some high authority at the Hospital, and consider the opinion therein contained as an expression of the public opinion in the Hospital.

It cannot be necessary to say more on such a point. Such an action must evoke, from all, the criticism, "bad form."

Of the third and last group of delinquents we see little, but unhappily we hear of them from time to time,—men who, while in the position of *locum tenens*, by carelessness and ill-behaviour prejudice the interests of the practice temporarily in their care; men who as hospital residents have from time to time been the means of closing the doors of hospital appointments to Bart.'s men, and men who avail themselves of the infinity of ways in which a practitioner may bring discredit upon his school and his profession.

Fortunately, owing to our predecessors, and the great number of men who at the present time are every day adding to the dignity and prestige of the hospital, there is but little fear of permanent harm resulting from the actions of the discreditable few. Still, public opinion might, if more vigorously expressed, do something to repress such men, and we leave our readers with the parting remark that there is a fountain in the square, which has before now been used as an educational method in such cases. New forms of treatment for all irregularities are constantly introduced,

and there is often true cause for fear lest in pursuing the new remedies we may inadvertently forget those that have proved themselves reliable through the "hoary days of antiquity."

A Teaching University for London.

ANY years have passed since the first proposals to reform the University of London, in the direction of giving it teaching as distinct from examining functions, were made. One of the earliest of these proposals arose in the University itself, when in 1864, Mr. Bompas proposed in Convocation that a special committee should be appointed to draw up suggestions for teaching by the University. These suggestions were drawn up, and sent to the Senate, only to meet with rejection. In 1878 Dr. Pye-Smith moved in Convocation a series of resolutions having the same object, and in the same year the Report of the Annual Committee contained proposals for bringing teachers, examiners, and the Senate into closer relations with each other, and for promoting higher University teaching. These proposals were adopted by Convocation, but nothing came of them. In 1881 the subject was again referred to in the report of the Annual Committee, and a resolution affirming the desirability of establishing Boards of Studies to advise the Senate on matters connected with the details of examinations, and to form a medium between teachers and examiners, was passed. This resolution was re-affirmed in January, 1882.

Thus there was, fifteen years ago, a strong feeling amongst the graduates in favour of modification of the University in the direction of a closer association of teachers with the management of the examinations of the University. This is instructive and interesting when we bear in mind whence some of the opposition to the best scheme of reconstruction which has as yet been proposed comes—viz. from a considerable party in Convocation.

It was not until early in 1884 that an association for the promotion of a teaching University in London was founded, and brought to a head what had been so slowly developing. The scheme proposed by this association, now long ago superseded by the many others which followed it, has the merit of being the first elaborated proposal for carrying into effect so desirable a reform as that which has for fifteen years been the subject of consideration. Since this scheme was propounded there have been certainly fifteen other schemes, and some minor propositions directed to the same object—or an average of one per annum. At times the balance of opinion seemed to favour reconstruction of the present University, at others the advocates of the foundation of a second University appeared to predominate. There have been two Royal Commissions, a great mass of evidence

has been taken, and the often conflicting interests of different teaching and examining bodies have been considered and urged by those interested. At one time it seemed that no solution of the problem was possible; at others matters seemed to be on a fair way to settlement.

We feel it necessary to thus briefly refer to facts which are well known to many of our readers, for we wish to emphasise the fact that many years of careful thought and work have been devoted to this subject, and as yet no tangible result has followed. We have felt for the past two years, and still think, that the time for action must now be very near. Never before have the various bodies interested been so near to practical unanimity, and the matter is of so vast importance to students of medicine in London that we wish to do our little to urge for a prompt settlement. There is, moreover, an element of danger that, through apathy on the part of those interested in the students' welfare, the tactics of the few remaining opponents—for all schemes, however good, curiously have opponents—may prevail. It may, therefore, be interesting to our readers to learn what has taken place in this question since the date of our last article in December, 1895. It will be remembered that in November, 1895, the teachers in the Metropolitan Medical Schools met and unanimously passed the resolution:

"That the Government be requested to introduce, at an early date, a Bill similar to Lord Playfair's London University Commission Bill, 1895, appointing a Statutory Commission to carry out the recommendations of Lord Cowper's Commission; but with an added clause giving (in accordance with precedent Acts of similar tenor) to all institutions or persons directly affected by any Statute or Ordinance proposed by the Statutory Commission a right of appeal to the Privy Council for the disallowance or alteration thereof previous to such Ordinance being laid before Parliament for confirmation."

A resolution in precisely similar terms was shortly afterwards passed at a meeting of delegates of *all* the institutions and bodies interested, and a deputation attended at the Privy Council Office, and waited upon the Duke of Devonshire. It will be remembered that the Duke's reply was not very encouraging. He appeared to have an altogether disproportionate idea of the character of the opposition which a party in Convocation offered to the proposed Bill, as well as an entirely erroneous notion of the "rights of veto" said to lie with the members of Convocation under the existing charter of the University. Amongst other matters he suggested that the objects desired could be obtained better by charter than by an Act of Parliament appointing a Statutory Commission.

We understand that the delegates who formed the deputation to the Duke, immediately proceeded to draw up a statement with the object of giving his Grace further information upon the subject, and of removing the erroneous impressions which appeared to have influenced the reply.

This statement was sent to his Grace in December, 1895, and had, no doubt, its share in influencing the Government in their decision upon the matter. In this statement the objections to proceeding by way of charter were very forcibly put by the delegates in the following words:

"(a) A difficulty must, we think, inevitably arise in answering the question by whom such a charter is to be demanded, or to whom it should be granted. The Senate of the University of London is, we believe, the only body competent to apply for a charter affecting the University which they administer. But it appears that the Senate has no desire or intention of applying for any such Charter; it has, on the contrary, expressed its almost unanimous opinion in favour of the method of procedure *laid down in the Report*.

"(b) Secondly, such a charter must include, not merely important points of principle, but many complicated details and regulations necessarily required to bring the new organisation into working order. Any attempt to settle the terms of such a charter would involve the renewal of all those tedious and ineffectual negotiations on which the Senate and other bodies concerned were for a long time engaged, and the unsatisfactory issue of which has brought home to the minds of all the conviction that the question is one to be settled only by superior authority.

"(c) Thirdly, even were the Senate willing to make the necessary application, and for that purpose to assume the responsibility of framing a draft charter, to carry out what might be agreed on between themselves and the various bodies concerned, it is more than doubtful whether those other bodies would be willing to enter into such a treaty, or to commit the future success of the necessary reforms to so doubtful and precarious a venture.

"We submit, therefore, that the conclusion at which we have arrived on this point is fully justified by experience, as well as by the fact that the method of proceeding by way of Statutory Commission has been so repeatedly followed and approved by Parliament, as to have settled into a recognised course of procedure in cases similar to the present."

In June, 1896, the decision of the Government became known, when the Duke of Devonshire introduced into the House of Lords a Bill to appoint a Statutory Commission, similar to Lord Playfair's Bill of 1895, but with the added clause asked for by the deputation of delegates of the institutions concerned, giving a right of appeal to the Privy Council. Thus the whole of what was asked for by the institutions concerned, the Government was prepared to grant; and as both Liberal and Conservative Governments had introduced similar Bills, it seemed highly probable that, at last, some substantial progress would be made. But again opposition proved, at the end of a Parliamentary session, to be too strong. It will be remembered that throughout the period intervening between the

Report of Lord Cowper's Commission, and the substantial agreement of the institutions concerned, the attitude of King's College had been very doubtful, and it was not without very important reservations that King's eventually agreed to join with the other institutions in asking for an Act to appoint a Statutory Commission. When the Bill of last Session was introduced into the House of Lords, those interested in King's College pressed for an amendment introducing a clause into the Bill in regard to the special circumstances of King's College.

This amendment having been agreed to, the Bill passed the House of Lords, but when sent to the House of Commons there was no time even to introduce it in the few days which remained of the Parliamentary session, except as an unopposed measure. But it is an open secret that some friends of King's College were not altogether satisfied with the amendment agreed to in the House of Lords; and secondly, that some opposition was threatened on behalf of the unsatisfied party in Convocation. For these two reasons it was impossible to proceed further during last year.

The Parliamentary session of 1897 has begun, but as yet no sign of a Bill has appeared. We have been informed, however, that it is probable that the Government will reintroduce the Bill into the House of Lords, and the present danger is that opposition may again have the effect of compelling the postponement of legislation through pressure of business. We have heard rumours of a movement in favour of abandoning the Bill, and endeavouring to proceed by way of charter. This we are convinced would be an absolutely fatal proceeding, and we understand that at a meeting of the Committee of Graduates of the University recently held, this view was unanimously expressed in a resolution urging on the Government the introduction of a Bill without delay. We hear also that similar resolutions have been passed within the last week or two by several of the institutions concerned, including the Medical School of St. Bartholomew's Hospital.

This, we are informed, is the present position of affairs, and it behoves all those who desire a speedy and satisfactory solution to put their shoulders to the wheel, and to do all in their power to get an Act of Parliament passed during the present session.

Pathological Settings.

By A. A. KANTHACK, M.D., Lecturer on Pathology.

IV. AMYLOID CHANGES.

BY amyloid changes we understand the appearance of curious deposits in certain tissue elements, which, when extensive, renders them not unlike boiled starch, and transform them into glassy or hyaline

masses. These deposits can be readily demonstrated by chemical reactions, of which the following are commonly used. (a) A solution of iodine stains the amyloid portions a deep mahogany brown, which, on addition of sulphuric acid, becomes bluish or violet. It was on account of this modified starch reaction that the name "amyloid" was given to this substance. It is, however, difficult to obtain the blue tint, and generally we have to stop short at the first part of the test, viz. the mahogany coloration. (b) Methyl violet stains the amyloid material red, leaving the other parts bluish or violet; the reaction is best marked if, after staining with methyl violet, the tissues be washed in water acidulated with hydrochloric or acetic acid. Gentian violet may also be used. It must be remembered that other substances, such as "colloid" and "hyaline," occasionally stain exactly like amyloid, so that we must not regard everything that reacts red with methyl violet as amyloid. According to Lubarsch, the methyl violet test is convincing—(a) wherever iodine or iodine-sulphuric acid gives a positive reaction; (b) in the absence of the iodine or iodine-sulphuric acid reaction wherever the substances which stain red with methyl violet optically, chemically, and topographically agree with genuine amyloid, or (c) appear under conditions which are generally associated with amyloid degeneration.

What is Amyloid?—Although by general consent considered a proteid, amyloid does not react like an ordinary albumen, and it is stated that it resists digestion. Recent observers, however, have asserted that in a finely divided condition it will undergo both peptic and tryptic digestion, and will dissolve on heating in water or alkalies. Its albuminoid nature even has been doubted, and it certainly has never been prepared in a pure form, so that we must confess that the chemistry of amyloid is still unknown.

Causes of Amyloid Changes.—(1) The commonest cause is chronic suppuration, and especially that accompanying tuberculosis and syphilis; but any form of chronic suppuration, if only chronic enough, may lead to amyloid changes. More especially may be mentioned chronic pulmonary phthisis, tubercular disease of the bones and joints, syphilitic bone disease, ulcerating cancers, varicose ulcers of the leg. (2) Tuberculosis and syphilis without concomitant suppuration may also lead to amyloid disease; so may (3) actinomycosis and leprosy, (4) Bright's disease, and (5) various forms of grave anæmia and cachexia. When syphilis is present it invariably shows itself as the tertiary or congenital form. However, the common cause to bear in mind is chronic suppuration. But if we review the various lesions with which amyloid changes may occur, we find that the common factors are (1) continual loss of albumen, producing chronic anæmia, or marked hydræmia; and (2) it appears, infective processes, or at least processes which are readily complicated by secondary infections, such as suppuration and ulceration. We have, however, but little

knowledge regarding the origin of the amyloid substance itself.

Birch-Hirschfeld has analysed 262 cases, and in these there were present—

	Times.
(1) Chronic tubercular disease of the lungs ...	140
(2) Pulmonary phthisis and bony tuberculosis...	21
(3) Pulmonary phthisis and intestinal tuberculosis	18
(4) Pulmonary phthisis and syphilis ...	2
(5) Bony tuberculosis alone ...	28
(6) Chronic suppuration of bone (non-tubercular)	4
(7) Syphilis (gummatous, especially in liver) ...	15
(8) Cancerous ulcers	5
(9) Varicose ulcers of leg ...	3
(10) Visceral suppuration	8
(11) Actinomycosis	1
(12) Noma	1
(13) Peritoneal tuberculosis...	4
(14) Chronic arthritis	1
(15) Suppurative cystitis and pyelitis ...	1
(16) Doubtful causes	10
	—
	262

Localisation of Amyloid Changes.—In general amyloid disease we find that certain organs are more especially selected, and as a rule several of them are simultaneously affected. Particularly favoured are the liver, spleen, kidneys, supra-renal capsules, lymphatic glands, and intestinal mucosa, especially that of the large intestine. Thus in 269 cases Birch-Hirschfeld found amyloid changes—

	Times.
In spleen alone	35
„ liver „	2
„ kidneys „	1
„ spleen, liver, and kidneys	142
„ spleen and kidney	77
„ spleen and liver	10
„ kidneys and liver	2

The spleen is, therefore, oftener affected than any other organ in the body.

Experimental Pathology.—Numerous attempts have been made to throw light upon the origin, nature, and distribution of amyloid changes by means of animal experiments. Most of them have been negative, but a few positive results have been recorded, and of these those of Czerny and Krawkow must be specially mentioned. The former kept up a chronic suppuration in dogs by means of turpentine and nitrate of silver injections, and found that the spleen and liver invariably showed amyloid changes; with rabbits, however, he was less successful. Examining the pus corpuscles and leucocytes he found that during the experiments they showed granules which stained dark brown with iodine, and turned blue on adding sulphuric acid. Czerny

assumes that this substance is pre-amyloid matter, which is carried by the leucocytes to the tissues, deposited there, and then changed into amyloid. Similarly, he found that during suppurative processes in man pre-amyloid substances appear in the leucocytes, so that he concludes that the precursors of amyloid are formed in the pus,—whether micro-organisms are present or not is immaterial; that they are diffused or distributed in the various organs and deposited there as true amyloid, and that this deposition shows itself first in the spleen. According to him, then, we have an infiltration of the tissues, and not a degeneration.

Krawkow repeatedly inoculated rabbits and other animals with pure cultures of the *Staphylococcus pyogenes aureus* until they showed marked wasting, and readily produced amyloid changes in their organs, which with them also began in the spleen, and in every detail agreed with what is observed in man, macroscopically or histologically. He believes that microbic infection is absolutely necessary. Numerous other observers, including myself, have failed in obtaining results similar to those of Czerny or Krawkow, and therefore, in the absence of confirmatory evidence, judgment must be suspended, for the few positive results obtained hitherto do not altogether outweigh the far more numerous negative ones.

How is the Amyloid Substance deposited in the Tissues?—

There exist two conflicting views: (1) either the amyloid is produced *in situ* by the cells from their albuminous constituents, or (2) it is formed in the blood and carried to the tissues; *i. e.* we are dealing either with a degeneration or an infiltration. Formerly it was believed that amyloid was formed in and by the cells, and then deposited from them by a process of infiltration into the intercellular tissues; but now it is generally believed that amyloid matter never appears in epithelial cells, but only in the interstitial tissue, although so good an observer as v. Recklinghausen still speaks of intercellular and intracellular infiltration. Wichmann considers it as established that it is exclusively the connective tissue which contains the amyloid, whether it be deposited there by a process of degeneration or infiltration. So far we cannot come to a decisive opinion, because experimental evidence assists us but little. If Czerny's observations be accepted, then indeed the amyloid change is an infiltration. On the other hand, neither Virchow nor any other observer has ever detected amyloid in the blood. It is undoubted that in the earliest stages the amyloid appears in the intercellular substance; but it is uncertain whether it develops *in situ* or passes out from the cells. Thus, with regard to the liver, it has been stated by some observers that the amyloid is deposited first in the hepatic cells; but others, and especially more recent observers, emphatically deny that these cells ever show amyloid changes, so that, according to the most recent investigations, it is held that amyloid changes never occur in (a) epithelium, (b) striped or

unstriated muscular tissue, or (*c*) leucocytes, but that the deposition is always an interstitial one, and that the tissue cells degenerate through pressure exerted by the amyloid tracts. Accordingly, then, so far as the liver is concerned, the epithelial cells are never amyloid, nor are they in the kidney or intestines; but it is almost certain that in the spleen amyloid changes may occur, not only in the reticulum, but also in the cells, which, however, are not epithelial. We see, therefore, that this question also must be left open.

All observers, however, are agreed that the amyloid changes during the earliest stages are most frequently observed in or along the capillaries and smallest arterioles. Their walls become swollen and their lumen narrowed: in the arterioles the amyloid matter is deposited in the middle coats, the muscular elements remaining intact, the material appearing in the connective tissue; and in the capillaries it is deposited in the interstitial substance of their walls. From there the amyloid change extends into the surrounding tissues, implicating, according to most observers, only the connective tissue; according to some, also the parenchyma cells, *i.e.* the hepatic cells if the liver be affected, the spleen pulp in case of the spleen, and the tubular epithelium in case of the kidney. If we subscribe to this latter view, then it is evident that an amyloid change is an infiltration rather than a degeneration. This is, however, a point hardly worth discussing, because the effect of the amyloid change must be cell degeneration and impairment of function. In the liver and kidney the epithelial cells outside the amyloid tracts always show marked fatty degeneration, and those within those tracts disappear altogether; and when vital organs are concerned the final results must be anæmia, hydræmia, marasmus and death. The amyloid matter not only presses on the cells, but also on the vessels, and this produces vascular obstruction, which, if arterial, still further impairs nutrition and function; and, if venous, may lead to œdema and dropsy. Thus in amyloid disease of the liver ascites due to portal obstruction is common; in amyloid disease of the kidney albuminuria is not uncommon.

Why the amyloid substance is first deposited in the middle coats and walls of the arterioles and capillaries we do not know; but there is no reason to believe that it is a primary degeneration of these parts, because we find the arterioles and capillaries affected only in those regions which are actually diseased, and not elsewhere; and it may also be remarked that when an amyloid change appears in the kidneys as the result of chronic nephritis, it is most marked and begins first in the kidneys.

Can an Amyloid Change, once in Progress, come to a Standstill and disappear? i.e. can amyloid substance, once formed, be reabsorbed? This is an important question which Litten attempted to answer experimentally by placing fragments of amyloid tissue in the peritoneal cavity of rabbits.

He obtained all the changes which generally appear on placing foreign bodies in the abdominal cavity, but what was left of the amyloid tissue no longer gave the methyl violet reaction. It is further known that wandering cells may ingest amyloid matter. Clinically, it appears, there is some evidence that occasionally an amyloid liver may diminish in size, and that an amyloid change may gradually vanish. It must, however, be remembered that the clinical diagnosis is by no means always certain. We may assume, then, on returning to Litten's experiments, that the cells which aggregate around a foreign body are capable of ingesting, dissolving, and removing amyloid matter, but further we cannot argue.

We may now briefly consider the amyloid processes in the chief organs.

(1) *Liver.*—(*a*) In the earliest stages they can be detected only on staining with methyl violet. Some lobules are quite free, but the affected ones show the changes in the intermediate zones. The amyloid is deposited along the capillary walls, compressing and pressing upon the liver cells, which themselves are not affected.

(*b*) In advanced stages the liver is enlarged and firm, smooth, and opalescent on section. The degeneration affects the central and intermediate portions of the acini. What is left of the liver cells must be looked for at the extreme periphery or the extreme centre of the lobule, and those at the periphery are almost always in a state of fatty degeneration. In the amyloid zone nothing is found of the cell outlines; the cells have vanished, or only the merest remnants are found.

(2) *Spleen.*—Here either the follicles (sago spleen) or the pulp (wavy spleen) become changed.

(*a*) Wavy spleen: the capillaries are surrounded by amyloid tracts which extend along the reticulum, gradually compressing the spleen cells, and pressing upon the follicles.

(*b*) Sago spleen: the reticulum of the follicles becomes amyloid, the follicles are large and transparent, and the lymphocytes eventually disappear altogether through pressure.

(3) *Kidneys.*—The amyloid changes are best observed in the cortex, but are present also in the medulla. In the cortex the glomeruli, membranæ propriæ, arteries, and capillaries are affected, and in the medulla the vessel walls and membranæ propriæ, but as stated by modern observers the renal epithelium never suffers. The glomeruli become enlarged and transparent, and are filled by amyloid capillary loops; the nuclei of the glomerular epithelium disappear.

(4) *Intestine.*—The amyloid changes are observed in the walls of the vessels of the villi, mucosa, and submucosa, and in the reticulum of the villi.

(5) *Lymphatic Glands.*—The reticulum becomes amyloid, and we obtain appearances resembling those described in the spleen.

Occasionally amyloid changes may appear locally, as in

the conjunctiva and in the connective tissue, or in tumours. These processes require no special discussion or description.

In my next article I shall consider the process of Acute Inflammation.

Bees and Medicine.

By JOHN GUTCH, M.A.

SOME apology is, perhaps, due to the readers of the JOURNAL from the writer of this article, for the subject is one that deals with the past, almost prehistoric times, whereas we of to-day are thinking mostly of the present or future. My reason for writing on such a subject is twofold: first, my great interest in bees; and secondly, the fact that medical men have, from the earliest ages, made the study of bees the theme of many writings. For these reasons I crave your indulgence whilst I put before you my gleanings from a selection of old authors on the subject. Amongst the early writers, including medicals and those not of the faculty, I may mention Pliny, Virgil, Hippocrates, Galen, Mousset, Androvandus, Warder, Moses Rusden, and others. Truly it is a subject, perhaps you will say, almost threadbare; it has been so often written about. Mousset, an English physician, mentioned above, who died about 1600, estimates the number of authors who wrote about bees before his time at five or six hundred; how great their number must be now I can only leave you to conjecture.

But I have said enough by way of introduction. So many are the healing virtues with which bees and honey are credited, that there are but few ills to which human nature is heir which, according to the ancients, were not curable by their use in one form or another. Some few of these virtues I will now mention. First, "the eating of honey gives long life and health;" surely, then, it must have been popular. "Yet honey was the symbol of death as gall is of life. Wherefore the ancients offered honey in sacrifice to the infernal dieties, for, because of pleasure, death creeps on us." It was known also as a cure for toothache, deafness, spots in the eyes, jaundice, gout, sciatica, dropsy, palsy, agues, distempered spleen, cough, difficulty in breathing, asthma, burns, for the healing of all wounds and ulcers, for the diminishing of fevers, as a remedy for baldness and as a hair-dye, as a slayer of lice and nits, as a diuretic and oxytoxic. Truly a goodly list, you must admit. Authorities did not, however, agree in those days any more than they do now, for Galen forbids honey to such as were hectic, had a fever or the jaundice, and young men. The same writer says, "Honey warms and clears all wounds and ulcers, attenuates and discusses excrecences in any part of the body." It is very effectual to produce hair in baldness, he says; and Chares, a

physician about 1690, recommends the ashes of bees for this purpose. The same writer urges the use of "oil of honey distilled for quotidian agues, and for producing a smooth skin, diminishing heat in fevers, and quenching thirst."

"For exulcerated ears" Galen recommended "honey infused warm by itself, especially if they cast forth ill savour, as also for their singing and inflammations."

Bees drowned in honey are recommended for clearing the eyes, for staying vomiting, and as profitable for deafness. When used for clearing the eyes the eyes are to be anointed; but this caution is added, "First bind the party, for such is the violence of the medicine that he cannot otherwise patiently endure it; but the benefit is so forcible that in the third day it will make a clear sight."

Pliny most of all recommends honey which the bees gathered in dog-days, almost thirty days after the solstice, for, saith he, "After the rising of every star, especially the greater ones, or the rainbow, if flowers follow not, and there be a warm dew with the rays of the sun, medicines, not honey, are produced, heavenly gifts for the eyes, ulcers, and bowels."

Hippocrates says, "Honey mixed with other things nourisheth; but eaten alone attenuates rather than refresheth, for it provoketh urine and purgeth too much." Honey rubbed into the gums he recommends, "for it conduceth wonderfully to the generation, conservation, and whiteness of the teeth."

Celsus gives the following remedy:—"The bodies of bees taken newly from the combs and powdered and drunk with Dierretick wine, powerfully cures dropsy." Oxyssel made of water, vinegar, and honey, is recommended "for driving away thick and gross humours, and as profitable for sciatica, falling sickness, and the gout, and as good also to gargarize with in a squimancey."

Oil of wax, a lengthy receipt for the preparation of which is given by Androvandus, is said "to help the palsy and sciatica, contracted nerves by anointing or drinking of it, to conserve the memory, confirm the brain, assuage the toothache, free the lungs from thick superfluities, to heal the cracks and chaps of the lips and paps, and hinder not the child from sucking, and for bringing forth the dead or living child."

"Wax," says Galen, "after a sort, holds a middle of things that heat, cool, moisten, and dry;" and both Dioscorides and Pliny prescribe it for internal ulcers of the bowel.

One more curious remedy I must mention before I conclude, and it surely is the strangest of all. Baths of honey are spoken of as being admirable for aches and strong itches. Remnant thus speaks of it:—"A friend of his had such a foul itch that he was like a leper, whom he thus cured. He took an empty wine cask, called a pipe, and took out one head, and made a liquor of water

and honey, making it pretty strong with the honey, and heating it as hot as he could endure to stand in it, and put it in the pipe and caused him to stand in it up to his neck a pretty while, and this he did three days, one after another, and he was recovered as clear as ever. If it be renewed with a little honey every day it will be better.

Such are a few of the curiosities of ancient therapeutics, and they will, I hope, prove as interesting to others as they have done to myself.

The Details of Ovariectomy and Disputed Points in After-Treatment.

By ALBAN DORAN, F.R.C.S., Surgeon to the Samaritan Free Hospital.

A Paper read before the Abernethian Society on November 12th, 1896.

(Continued from p. 55.)



We are now back again to the abdominal wound, and must think a little about sutures. Altogether, silkworm gut is the best material, at least for the deep sutures. It was first used nearly twenty years ago by Dr. Bantock, at the Samaritan Hospital. I see that you approve of it here. Mr. Cripps has adopted it, and Mr. Lockwood finds that "it is quite unirritating, and owing to its physical properties has no capillarity." He states that "one or two boilings seem to have no effect on it," but I find that it is quite needless to boil the gut. It must always be soaked in cold water or antiseptic solution for at least twenty minutes before use, and it is good to keep it in lotion.

Catgut is necessary for deep, sunken sutures, continuous or interrupted. I use it when uniting the aponeurosis and muscle.

We must not allow hernia to develop, if we can avoid it. We cannot always avoid it, for this complication is the patient's fault in not a few cases. They often put aside belts far too soon. *Do not be under the erroneous impression that the hernia always develops at the lower extremity of the wound.* I have seen several bad herniæ high up an ovariectomy cicatrix. Do not blame the material for suture; thus silkworm gut never gives trouble if not pulled too tight. Also beware of the value of new methods. At the Geneva Congress last September there was a long discussion on the closure of the abdomen. Every speaker reported the best results after the adoption of his *last* method; but Savory long ago noted the fallacy which underlies arguments of this kind. It is in the old operator, rather than in the new method, that the improvement usually lies. As regards the material for suture, we can see the truth at once. Silk may do well, silkworm gut may do well, and wire may do well. But the divergent practices of deep sutures, including all layers or sunken sutures of the deeper layers of the abdominal walls, come under the same argument. Beginners often handle the tissues too much and not too tenderly, so that sunken sutures in layers may involve great mauling about of muscle, aponeurosis, fat, and skin. If deep sutures only be used, they may be pulled too tightly. After some experience the operator handles tissues more gently; then he must discount the value of the method he rejects or adopts.

A single set of sutures passed through all the layers, including the rectus itself as well as its sheath, answers well in a wound of average depth. Several German precisians, after examining for years after operation many patients submitted to this method, make out no larger percentage of herniæ than occur after opposite practices, nor can we feel sure how far any patient with a hernia may have neglected precautions. When retraction of the sheath of the rectus is marked, and in plump and fat subjects, it is always right to unite its edges with a continuous catgut suture, including the muscle on each side. On the other hand, this sunken catgut suture is advisable when the walls are very thin and damaged by long distension, as firm union of the atrophied structures is needed before the muscles regain their strength.

I consider that separate union of the peritoneum is unnecessary in ovariectomy (it is otherwise in supra-vaginal hysterectomy). The deep suture passing through all layers will secure the peritoneum perfectly if the needle be passed within a quarter of an inch of the cut edge of the serous membrane. This causes eversion and perfect apposition of the inner surfaces of the sutured peritoneum. *Within a few hours union begins quite unhindered by vomiting.* Remember, however, that the edges of peritoneum are everted. Do not, then, pass the needle too far from the border. This error was once common; I have seen the cut edges side by side lying level with the skin after the tying of the sutures. Thus the everted serous surfaces effectually prevent union of all the anterior layers; and when the sutures are removed there is a hernial pouch ready made.

The sutures must be pulled just tightly enough to bring the edges of the wound together, allowing for œdema. The conditions are quite different to what is seen in the pedicle, where the ligature *must* be pulled tightly. But you are all good general surgeons here, and so understand well enough about tying sutures. The knot should be tied somewhat to the side of the line of incision. A few superficial sutures including the fat are needed in fat subjects.

The wound being closed, all harm is shut out—though, maybe, some harm may be shut in. The dangers of the drainage-tube must be met by proper management of the drainage-tube; but when a wound is closed completely, and there is no tube, there is practically no danger of entry of infection. The days are gone when some surgeons turned spray on the dressings and skin when taking a look at the wound a week (or sometimes more) after the operation. Immediate dusting with iodoform is excellent. I apply alembroth gauze to the wound, as oozing and perspiration damp the dressing, and thus set free a disinfecting agent. Plain absorbent gauze may get foul if soaked, and stick to the wound, and then a drop of pus may often be found at the point of adhesion.

Pads are a question of dressing which you all understand. When the patient is very thin, or the abdomen very concave, it is best to strap over the pads. In a fat subject, or when the abdomen is convex, the straps must be applied first. I am a great believer in strapping, having seen bad results where it is not used. I also prefer a short, many-tailed binder to a bandage in one piece, or to a binder with very long tails. Short tails may be easily adjusted with safety-pins, according to local necessities or the patient's comfort; this I know from very long experience in after-treatment. Remember that the most superficial tails should come uppermost when there is no drainage-tube, as that arrangement insures the firmest pressure. When there is a tube in the lower part of the wound, the most superficial tails must come lowest, so that they can be undone during management of the tube without disturbing the rest of the binder.

We now come to that very complicated subject, after-treatment. I know of one excellent operator who always gives opium, and finds that the patients do best in every respect with that drug. Another, who can claim equally good results, is of opinion that opium is a curse to humanity, and never uses it in any form. Several successful operators insist on saline purgatives within three or four days after the operation, and use salines earlier as a panacea for all complications. Others find the patient does well if the bowels be left alone for a week. The diet question is even more complicated.

Now, it is not wonderful that so many varieties of treatment prove satisfactory. There is always more or less shock, but even weak patients may survive severe shock. Feeding by the mouth is usually not tolerated during shock, but it is sometimes borne, and injudicious early feeding may cause salutary though unintended vomiting. A patient may never vomit from the first yet do very badly otherwise, and it may be through faulty dieting, or it may not. In fact, recovery is the rule, and it is not always easy to distinguish recovery due to right treatment from recovery in spite of bad treatment. The ways of therapeutics are far more obscure than the paths of surgery!

There is no royal road to treatment. We must not frivolously say, as has been said, that it does not matter what the patient takes at first. We must be ready for special circumstances demanding modification of our line of treatment.

Yet no surgeon can dispense with a certain amount of routine—the sum of the experience of others, controlled by his own. What are known as "points of after-treatment" are specially suited for discussion.

Thus, as to position, it is altogether best that the patient should lie on her back. Bedsore is the chief danger of the supine position, but good nursing is a sufficient preventative against that complication. The position is said to hinder the escape of flatus and to allow of its accumulation in the stomach and transverse colon; but this assertion is questionable physiology, and the wearing of the rectal tube will counteract distension of the large

intestine. It is best to keep the patient quiet for a few days, and she can be more easily kept comfortable on her back than on one side; turning from side to side can never be allowed. The dangers of turning, of course, have been exaggerated, and sometimes it favours the escape of flatus.

As long as there is nausea, vomiting is to be promoted during the first twenty-four hours, especially when due to chloroform or flatulent distension of the stomach. The escape of air from a distended stomach always promotes the passage of flatus. Inhalation of a little vinegar on a piece of lint relieves the nausea of chloroform. Bicarbonate of soda in warm water is, in my experience, the best emetic.

Vomiting, when it sets in after the first two or three days, is always serious. The symptoms of sepsis and obstruction are well known to you. An attack of simple indigestion with vomiting is not always easy to distinguish from graver conditions, the pulse and temperature often rising in sickly dyspeptics. In these late vomiting cases it is good to take to enemata, and hot alkaline solutions are needed to empty the stomach unless obstruction be the most evident feature, then the upper part of the alimentary tract is best left alone.

Feeding is a question of the highest interest. Ordinary beef-tea enemata answer best in children, in all feeble patients, in all cases over 40, and in all where the operation has been prolonged and severe. After simple operations robust young women do not require enemata, unless there are signs of restlessness. I believe more than ever in beef-tea enemata; the application of the rectal tube before their administration encourages the downward passage of flatus, and the nourishment, without any disturbance of the stomach and small intestine, is particularly suited to the patient's condition.

I find that most cases get on very well without drugs, but I have seen so many do well with routine treatment by tincture of opium, sometimes *mx* in beef-tea enemata every six hours, that I cannot share in the prejudices of some surgeons against that drug. Great care must be taken to watch the patient when opium or morphine is given, especially as to excretion of urine and the retention of flatus; in the latter case belladonna should be added to the opiate. In a case of great nervous restlessness I gave 20 grains of trional and the patient slept within an hour afterwards; but in other cases I have found it absolutely inert.

When sickness has passed away, about two ounces of barley-water may be given every two hours, though it is best not to begin feeding by the mouth until flatus has passed, particularly in bad cases. Milk is not nearly so unsuitable as many authorities believe. A drachm of *Liquor Calcis Saccharatus* (not the simple *Liquor Calcis*) should be added to every pint of milk. Weak tea without milk or sugar may sometimes be taken as a drug when the patient's skin is dry, but always with caution, as it promotes flatulence.

No solid should be given till the bowels have acted. Beef tea sometimes causes the urine to become concentrated; in such cases farinaceous food is advisable, with mutton broth if the patient be weak.

You are in a good position here to understand the signification of temperature in relation to the pulse. Abdominal surgery has carried with it in the course of its development a spirit of emulation which has led to great things, but has involved several evils, especially a love of record-breaking. Just as some operators boast that they can remove any tumour through a two or three-inch incision, others say that they have "no temperatures." I dwell on this kind of remark, because it covers a yet more pernicious idea not confined to specialists. This idea is, "Sepsis is a disease which has the peculiarity of killing other surgeons' cases; when I lose a case it is from purely accidental causes entirely unconnected with septic infection." Closely associated with this notion is the theory that high temperature and rapid pulse mean sepsis.

Now, in sepsis, the temperature keeps at a high range, not phenomenally high, in company with a rapid pulse. When we further observe flatulent distension, retching, and restlessness, the diagnosis of septicæmia becomes as certain as diagnosis possibly can be. Towards the fatal termination the hands and feet become relatively cool, the cheeks deeply flushed, the respiration very shallow, the pulse so rapid as to be counted with difficulty, and the temperature stationary, if it does not fall a little. You all know this clinical fact, but too much stress has been laid on rising and falling of temperature, to the neglect of the pulse, in the after-treatment of abdominal section.

Assuredly no operator likes to see the temperature rise, and a rise must always put him in mind of septicæmia. But the mere height of the temperature means little. The above clinical sketch of

septicæmia is a mere commonplace to you. Unfortunately, specialists may confuse two conditions, such as—

9 a.m.: Temp. 103° 8'; pulse 120,

1 p.m.: Temp. 104°; pulse 144,

9 p.m.: Temp. 102° 8'; pulse over 156, very irregular;

and 9 a.m.: Temp. 103°; pulse 132,

1 p.m.: Temp. 103° 4'; pulse 132,

9 p.m.: Temp. 104°; pulse 132, regular.

The first case implies a desperate condition. The second, if flatus passes well and there be no vomiting, is much less serious, and I have seen it on the third or fourth day after a severe operation, when metrorrhagia set in. In a fatal case of ovariotomy in a diabetic patient under my own care, the temperature rose steadily with the pulse till death. Flatus passed well, and even food was taken till within one hour of death. This was undoubtedly an instance of pure sepsis; some drops of foetid dermoid material had, I believe, escaped into the peritoneum. The passage of flatus was especially significant; there was no obstruction. Nevertheless, in undoubted septicæmia the temperature, as a rule, tends to rise less rapidly than the pulse.

The causes other than septic of high temperature specially deserve consideration. Flatulence is decidedly one cause, and of that symptom more will be said. The appearance of uterine "show" is closely associated with rise of temperature. I have often seen this phenomenon. The extreme bacteriologists would say that the rise was due to sepsis; I do not deny that this theory may contain a germ of truth. Others speak of neurosis; I do not contradict them. Retained blood and relics of endometrium may involve slight septic absorption, especially from changes close behind a ligature involving a uterine cornu. Again, women decidedly suffer from nervous disturbance in association with menstruation, and the temperature rises under such conditions. Sudamina, in rheumatic subjects especially, cause a considerable rise.

Why do too early visits of friends so often cause rise of temperature? The antiseptic party would say that the patient rises to salute a friend, or twists round to talk to a friend,—adhesions are disturbed, and a "focus" set loose. Yes, but restless patients after severe ovariotomies may struggle night after night, and sit bolt upright directly the nurse's back is turned, yet rise of temperature does not necessarily occur. Food may be smuggled in; but I have known of rises of temperature when the patient was closely watched by the nurse during the friend's visit, nor are these visitors so insubordinate as some may suppose. On the other hand, abuses may occur in respect to forbidden diet inside the hospital, and it is not a rise of temperature that necessarily betrays this evil.

High temperature in the second or third week, without general symptoms, may be due to inflammation of a suture-track, or to parametritis of the stump of the pedicle. These complications are not rare when the operator is inexperienced or somewhat heavy-handed. In parametritis the severity of the local symptoms, with high temperature, and yet little general disturbance, may be compared with the absence of all local symptoms, coincident with high pulse and temperature and marked constitutional trouble so often seen in septicæmia.

In simple and well-managed cases, late high temperatures nearly always signify retention of scybala. When they come away a fall is almost invariable; but in weak subjects some exhaustion follows the evacuation, hence the pulse may rise, the temperature falling, and in very debilitated subjects even a further rise of temperature is observed. But in a few hours the clinical symptoms become favorable.

By phenomenal temperature most writers mean 105°, 6', 7° or 8° without evidence of sepsis, obstruction, &c., and with ultimate recovery. As a rule, they can be explained. In one case, where the temperature nearly reached 106° on the fifth day, the patient informed us that she was subject to ague. In another, where I operated, the temperature rose to 104° during the third week, but the patient was phthisical. Both cases recovered after appropriate treatment. I cannot dwell on a case of hysterectomy (with the *serre-neud*) where the temperature rose to 107° in the second week, and fell in a few hours after wet-packing. Nor can I pause long on a case of operation for ectopic gestation, where I was alarmed by a rise on the eighteenth day to 106°, after two rigors. There was practically no constitutional disturbance; quinine was given, and two days later the temperature was subnormal. I am not sure that ague might not account for this case; influenza is less probable, as the patient felt neither pain nor prostration, which are never absent in that disease, and are very severe when high fever is present. Altogether, I suspect there was some menstrual disturbance.

Now the catamenia may certainly trouble the patient after ovariotomy, and I have said that menstrual blood in the uterus, weak after

a recent ovariectomy, might become septic. I have also said that neurosis is possible and probable, when I was dwelling on symptoms immediately after operation. At all events, a rise is often seen when the period is due a week or two after ovariectomy.

I fear that we cannot discuss at length the co-relation of peritonitis with sepsis or disturbances inside the gastro-intestinal tract. Not many years ago it was necessary to apologise for differing from the authors of text-books as to the clinical symptoms of peritonitis. Now I must almost make excuses for stating that I have once observed the sensational or ultra-acute type eighteen years ago, where the patient died of perforation of the small intestine ten days after ovariectomy. In another case of perforation, nine days after removal of a tubal sac, Blanc observed intense abdominal pain, distension, and acute dyspnoea. You know only too well the common subacute peritonitis of reality, which is "typhoid rather than sthenic," as we used to say. It is caused, we are told, by sepsis, or is absolutely correlated to and coincident with sepsis, or is caused by obstruction which first sets up peritonitis and then sepsis, or first produces sepsis and then engenders peritonitis. Leaving these deep pathological problems to Dr. Kanthack and other distinguished scientists, we must remember that more or less distinctly marked peritonitis with dull pain and rise of temperature certainly occurs after severe ovariectomies. The septic form is as dangerous as in pre-Listerian and aseptic days. Opening up the wound and irrigating usually kills the patient before the near period when she would have otherwise died in relative peace; the few reported recoveries of which I have heard seem to mean removal of obstruction caused by adhesions.

With great relief I come to a very practical subject—flatulence. Free passage of flatus from the rectum almost invariably signifies that the patient is not in any danger from any complication. Obstruction is not necessarily the cause of sepsis, as I have seen it absent in the case of diabetes already mentioned. But it makes septic, uræmic, and inflammatory symptoms worse, and when air can be made to pass these symptoms nearly always fall in severity or disappear altogether. Tympanitic distension during the third week or later, with no other unfavorable symptoms, is usually due to accumulation of scybala.

Having reviewed the more troublesome complications at some length, I may speak now of their treatment. The ice-cap is always advisable when the temperature keeps at 103° or rises higher; even hopeless septic cases are more comfortable when thus treated. Flatus passes easier when the cooling process brings comfort. In the neuroses—if they be neuroses—in association with metrorrhagia, the ice-cap is beneficial. Of all treatment, however, I say once more that ensuring the passage of flatus is the most imperative. It leads on to a special question—the opening of the bowels. Firstly, nutrient enemata must be continued when flatus fails to pass, as food by the mouth aggravates the symptom, and so does starvation, whilst the enema promotes the passage of flatus and keeps the patient from exhaustion. When these means fail, an injection of over a pint of gruel with 2 drachms of oil of turpentine should be slowly and carefully injected. If scybala come away, so much the better. Twenty minims of Tinc. Belladonnæ may be given in beef-tea enemata every six or eight hours if the flatulence continues.

We prefer this method, at the Samaritan Hospital, to Lawson Tait's saline purgative practice, which we admit is of some value. Coming to the question of opening the bowels, I always find that the simple enema, a few hours after an injection of 4 ounces of oil, is the best agent, and it need not be given till the evening of the sixth day. When, however, the tongue is foul, and distinct evidence of irritation of the gastro-intestinal mucous membrane exists, I find that it is better to give a compound colocyath pill, or 2½ grains of the compound extract every six hours, till the bowels act. The patient will then be better able to eat. I find that colocyath pills and extract answer better in this respect than castor-oil (which patients dislike), liquorice powder, or saline purgatives.

The dressing of the wound at the end of the operation has been described. As a rule it may be left alone for a week. Do not sacrifice, however, the patient's comfort to that evil principle, "Let me boast that I never touch my dressings for a week." Sweat rashes in some patients give great discomfort, relieved by change of dressings, even on the third or fourth day. A few sutures should be removed on the ninth day; indeed, if there be any that are clearly cutting, they may be taken away on the eighth, as they hinder healing. It is not good, however, to remove all the sutures till the tenth day, or even later, as the cicatrix is very liable to stretch when only a week old.

I much prefer to continue the application of strapping for some time after the removal of the sutures, and firm bandaging is needed. For never forget that the danger of hernia is not from without but

from within. Flatulent distension is a steady, sure, and direct agent in stretching the cicatrix, so it must be met by direct support, and strapping affords such support most effectually.

I will say no more, indeed I have probably said too much, more than can be duly considered on this occasion. You can now understand why I have been obliged to leave out several important questions. I have selected such as I deem best suited for discussion. In many matters relating to clinical subjects, temperature, peritonitis, &c., as well as in operative details, it is I that look to you for instruction this evening.

Ovarian Tumour with Amenorrhœa, simulating Pregnancy.

A case for diagnosis, under the care of Dr. CHAMPNEYS.
From Notes by Mr. EDDISON.



U—, æt. 38, a charwoman, was admitted to Martha Ward on October 14th, 1896, under the care of Dr. Champneys, suffering from pain in the neighbourhood of the stomach.

Her family history was good, and she had never had any serious illness. She has had seven children, the youngest having been born dead in July, 1895, at the end of the eighth month, when she suffered considerably from post-partum hæmorrhage. She has also had two miscarriages at about the third month, the last occurring in January, 1893. Nineteen years ago she was married at the age of nineteen, and her husband is still alive.

Her catamenia began at the age of twenty-one, after she had weaned her first child; three months after this she had a second menstrual discharge, and "saw nothing more" till she had weaned her third child. After this her periods never occurred at less intervals than six weeks, but generally every two months, the flow lasting three days; her last period was towards the end of May, 1896.

Two years ago she first noticed pain in the epigastric region, and during the last nine months she has changed from a rather florid to a pale complexion. For the last four months the patient has had great pain in the epigastric and right iliac regions, with retching and vomiting in the morning, and often is unable to take food till midday.

The pain has become worse in the last two months, and she has had vomiting after taking food at any time of the day. She has lost flesh since the middle of September, and has not been able to wear her clothes at all tightly round the waist. She has had no hæmatemesis nor melæna.

Her present condition is that of an anæmic and poorly nourished woman with a pale furred tongue. Her pulse is 76, regular and of small volume. Her temperature is normal. She has not much appetite, but sleeps well. Her bowels are open two or three times a day. Urine acid, no sugar nor albumen; lungs and heart healthy. On examination by Dr. Champneys—

P.H.—A rounded tumour reaches nearly to the costal arch. It is more prominent on the left than on the right; it is freely moveable beneath the abdominal walls, a wave of fluid is obtained over it; its consistency varies much in different parts, the prominent part on the left being elastic, whilst above and below this are hardened masses; nowhere is there fluctuation; no souffle, and no fœtal heart can be heard. The breasts are quite inactive. P.V.—The cervix, which is to the left at the usual level, has been cleft as far as the vaginal reflexion; its texture is firm and the canal is closed. B.M.—The abdominal tumour seems to be entirely above the pelvis. The cervix was seized with a volsella and drawn down, the finger passed *per rectum* felt about one and a half inches above the os externum, apparently unexpanded; above this, slightly larger, being about the size of an unimpregnated uterus, is a body continuous with it, and closely attached to the right side of the tumour. Movement of the abdominal mass scarcely affects the cervix. *Per speculum* the vagina is not characteristically livid. The sound passes two and a half inches with its concavity forwards and to the right.

The diagnosis was now an ovarian tumour, with perhaps a gastritis. On October 26th Dr. Champneys saw the patient with Mr. Bruce Clarke, and as her general condition was much improved, it was determined to operate on October 30th. At the operation on this date the abdomen was opened by a vertical incision in the middle line about six inches in length. Some clear straw-coloured fluid came from the abdominal cavity. The tumour was now in view, and a Spencer-Wells trocar was inserted in it; a viscid opalescent fluid, at first of a whitish-yellow colour, but afterwards changing to brown

and to a greenish-brown, was drawn off. Part of the omentum was adherent to the wall of the tumour; this was ligatured and cut off. The tumour was semi-solid, and the opening having been enlarged, and the broad ligament on the right side having been ligatured and cut, was removed. The peritoneum was sewn over the stump with fine silk, the abdomen washed out with warm water, and the wound in the abdominal wall sewn up. No evidence of gastric ulcer was found on examining the stomach.

The wound was dressed with iodoform, cyanide gauze, and wool. Since the operation the patient has done extremely well; her temperature has not been above 100° F. On November 3rd she passed three motions without pain, and vomiting has been not troublesome.

Remarks by Dr. Champneys.—The first aspect of the case was naturally that of pregnancy. In favour of this there were practically two symptoms (amenorrhœa and vomiting) and one sign (the tumour).

Against it were the shrivelled breasts, the firm cervix, and the excessive size of the tumour (nearly to the costal arch at the fifth month).

This excessive size was not due to fluid such as liquor amnii, for the tumour was firm on the whole, and the hard parts were not obscured by fluid. These were the points which excited my suspicions.

On further examination an endeavour was made to separate the uterus from the tumour by pulling the cervix down with a volsella. Although the top of the fundus could not be reached by the rectum, it was possible to feel above the situation of the cervix in the pregnant uterus, and to ascertain that the cervix did not expand into the tumour, though it was closely attached to it. The sound was then passed, and the diagnosis completed.

The stomach was inspected at the time of the operation (that is its anterior surface) and nothing found, but the pain and vomiting with increasing anæmia make it likely that a gastric ulcer was brewing, and that this was the cause of the fallacious amenorrhœa.

Palsy: a Word.

By W. MAWER.

FOR many years I have associated in my thoughts with the word *Palsy* those tremblings of the limbs and other parts which are seen in paralysis agitans, disseminated sclerosis, and bulbar paralysis. I was recently surprised, however, by observing that in medical literature shaking was not an essential part of palsy. This led me to ask a number of people (outside the profession of medicine) what ideas they attached to the word. Almost invariably the answer began with something about shaking, quivering, trembling; so that I decided that the proper meaning of Palsy, at least in our time, was what is sometimes specially marked out as "shaking palsy," since many of those whose impressions I sought were well educated and intelligent folk. I was reassured by finding that if I had been in error all my life, I was, anyhow, supported by a great many estimable people! But, alas! my boy (who is only in his teens, and does not yet know how dictionaries are made) maintains that I must be wrong, because all the dictionaries are against me; nor would he accept as an argument the suggestion that possibly there was behind some far shelf in the Bodleian another dictionary which he had not consulted.

And dictionaries are truly marvellous things, as every luckless wight who has had need to go to them knows. Thus:

"PALSÝ: a disease wherein the body or some of its parts lose their motion, and sometimes their sensation, the causes being an impeded influx of the nervous spirits into the villi of the muscles."

And thus:

"Its cause is usually supposed to reside in the ventricles of the brain, or in the root of the spinal marrow."

Where motion only is lost,—

"These causes affect either the blood or muscles; the former by thickening that humour, so that it cannot rarefy."

Where sensation only is destroyed,—

"They may be all those things which so far thicken the animal spirits in the nerves arising below the cerebellum."

Traced through its etymology, as far as I have been able to see, *palsy* is simply synonymous with *paralysis*. From *παράλυσις* we get to the old French *paralysie*, or *palasié*, and to the middle English *palasie*, *palasye*, *palsye*, and *palsey*.

"There our Lord heled a man of the palsye, that lay 38 ȝeer."
Mandeville, 'Travels' (14 c.).

And wherever *palsy* occurs in the New Testament, the Greek is *παράλυσις*.

Though the dictionaries and etymology fail me, I can gather comfort from the use writers have made of the word. But not always, seeing that often we can only surmise their meaning.

"Doth beg the alms of palsied eld."

Measure for Measure, iii, 1.

"This arm of mine,

Now prisoner to the palsy."—*Richard II*, ii, 3.

"And with a palsy-fumbling on his gorget."

Troilus and Cressida, i, 3.

"Palsied all our deed with doubt,

And all our word with woe."—*Matthew Arnold*.

"A poor, weak, palsy-stricken, churchyard thing."

Keats, 'Eve of St. Agnes.'

"The guts-griping, ruptures, catarrhs, loads o' gravel i' the back, lethargies, cold palsies, raw eyes, dirt-rotten livers, wheezing lungs, bladders full of imposthume, sciaticas, limekilns i' the palm, incurable bone-ache, and the rivelled fee-simple of the tetter."—*Troilus and Cressida*, v, 1.

"The paralytic who can hold her cards,

But cannot play them, borrows a friend's hand

To deal and shuffle."—*Cowper, 'Task.'*

"Cured lameness, palsies, cancers."—*Tennyson, 'St. S. Stylites.'*

"Infancy,

Or old bedridden palsy."—*Tennyson, 'Aylmer's Friend.'*

"Palsy, death in life, and wretched age."

Tennyson, 'Lucretius.'

None of these examples help me, but I will quote some which *do*.

"Dick: Why dost thou quiver, man?

Sav: The palsy, and not fear, provokes me."

2 King Henry VI, iv, 7.

"What drug can make a withered palsy cease to shake?"

Tennyson, 'Two Voices.'

"A universal shivering palsied every limb."

Barham, 'Ingoldsby Legends.'

"What you have spoke, I am content to think

The palsy shook your tongue to."

Baumont and Fletcher, 'Maid's Tragedy,' i, 2.

And—

"Nought shall it profit that the charming Fair,
Angelic, softest work of Heaven, draws near
To the cold shaking paralytic hand."—*Prior, 'Solomon,'* iii.

In Lincolnshire I have heard *Briza media* called palsy-grass, as well as trembling grass. The cowslip used to be known as palsywort, and is still so called in herbals, to indicate a virtue probably ascribed to it on account of the way its bells shake.

Notes.

MR. J. HOBDAV has taken the degrees of M.B. and B.C. in the University of Cambridge.

MR. J. M. WOOLLEY, who passed second into the Indian Medical Service, has maintained his position at Netley, being only one mark behind the first man. He has gained the Martin Memorial Prize for Medicine.

MR. J. H. HUGO passes out of Netley fifth, and has gained the Second Montefiore Prize for Surgery.

SURGEON-CAPTAIN ROBERT BIRD, M.D., M.S., F.R.C.S., D.P.H., has been appointed Examiner in Anatomy at the Calcutta University.

IN THE COMPETITION for the Army Medical Service recently held, Mr. C. H. Hopkins was second with 2207 marks.

MR. J. A. DREDGE has succeeded in passing into the Indian Medical Service at the examination recently held. He was fifth with 2574 marks. We understand that the competition was unusually severe on this occasion, for there were only seven vacancies, instead of as usual about fifteen, and the number of candidates was about the same as usual.

MR. D'ARCY POWER has been reappointed Examiner in Physiology in the University of Durham. Mr. D'Arcy Power has also been elected and admitted a Fellow of the Society of Antiquaries of London.

DR. J. H. DRYSDALE has been appointed Demonstrator of Pathology in the Medical School.

MR. T. STRANGEWAYS PIGG and Mr. C. P. White have been appointed Assistant Demonstrators of Pathology.

DR. J. CALVERT has been reappointed Demonstrator of Materia Medica and Pharmacy.

THE POST of Assistant Demonstrator of Materia Medica and Pharmacy is advertised as vacant. Applications to be sent in by March 8th.

THE MEDICAL SCHOOL COMMITTEE has decided to appoint an Assistant Curator of the Museum, and the post is advertised. Applications to be sent in by March 8th.

THIS MONTH we have to welcome yet another contemporary,—*The Middlesex Hospital Journal*. The whole style of this publication is excellent, and in this the first number the contents are well in keeping with the outside. We do not notice any statement as to the frequency with which succeeding numbers will appear, but whether fortnightly like "Guy's," monthly like ourselves, or tri-monthly like the "London," we sincerely wish them every success. It is interesting to note that until the appearance of this last child of hospital journalism the publications of all the London medical schools were called "Gazettes" with the exception of our own. Now there are two "Journals." With the exception of the *St. Mary's Hospital Gazette*, which is almost an exact reproduction, as regards style, of the *Guy's Hospital Gazette*, all the hospital magazines show a marked individuality. The form of the *Middlesex Hospital Journal* is rather suggestive of learned papers, deep thought, and general gravity. We venture to think that the Middlesex sporting editor must feel guilty of something akin to sacrilege in publishing sporting news in such a magazine.

WE NOTICE that Dr. A. E. Edwards, an old Bart.'s man, is President of the Leeward Islands branch of the British Medical Association.

W. LANGDON BROWN and G. A. Auden have taken degrees of M.B., B.C., and C. F. Lillie that of B.C. (Cambridge).

THE DEGREE of M.A. Cantab. (*honoris causa*) has been conferred on Dr. Kanthack.

R. J. NORMAN VOGAN, aged 11, is again a candidate (third application) at the coming May election for the Royal Medical Benevolent School at Epsom. He is the only child of the late James Norman Vogan, F.R.C.S., who was House Surgeon and Assistant Electrician at Bart.'s in 1884, and who afterwards practised at Ipswich till 1889, when he died, leaving his boy quite unprovided for. The child's mother had died in 1887. We sincerely hope that this candidature will be successful. The Rahere Lodge has promised its vote and the support of its members. Proxies will be received by Miss Vogan, Harpenden, Herts.

A VERY successful dance was recently given by the Bart.'s half-company of the Volunteer Medical Staff Corps. Up to the moment of going to press no success has attended our many efforts to get a satisfactory report; but we shall doubtless receive one in time for some subsequent issue.

Amalgamated Clubs.

HOCKEY CLUB.

THE above club, which was started last term, is getting on as well as a new club usually does. There has, of course, been some difficulty in arranging matches, as the club was started so late in the season. There were, however, two matches played last term, neither of which was won, but a fairly good show was made. A new secretary has been elected, as the original officer has the same post for the Cricket Club. Mr. Jeaffreson is the new one, and last week a match was played against Ealing, which resulted in a pleasant game being won by the visitors. There is plenty of keenness, and we see no reason why the club should not be a great success.

ST. BARTHOLOMEW'S HOSPITAL RUGBY F.C.

ST. BART'S HOSPITAL v. KENSINGTON.

Played at Wood Lane on December 5th. Kensington kicked off, and Bennett returned, and found touch near Kensington's "25." The ground was in very bad condition, and thus spoilt good play. The game was a series of scrummages, in which Bart.'s had the best. Just before half-time Kensington scored a try, which was converted. On crossing over, Bart.'s still held their own in the scrum, but were unable to score. Kensington then obtained another try, which was unconverted, the result being that we lost by 1 goal 1 try (8 points) to nil.

Team.—T. M. Body (back), H. Falk, S. Mason, T. A. Mayo, W. S. Danks (three-quarters), A. Hawkins, J. C. Sale (half-backs), H. M. Cruddas, A. J. W. Wells, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. Ll. Vaughan (forwards).

ST. BART'S HOSPITAL v. O.M.T.'s.

This match was scratched, owing to North v. South.

ST. BART'S HOSPITAL v. OLD LEYSIANS.

Played at Stamford Bridge on December 19th, and resulted in a win for Bart.'s by 3 tries to 2 tries. As we were very late in starting, the second half was played in semi-darkness. In the first half Mason scored a try, after a brilliant run. In the second half the Old Leysians scored twice; then Robbs, by good dribbling, scored twice for us, and so the game ended, as above stated, in a win for us by 9 points to 6.

Team.—T. M. Body (back), S. Mason, C. Dix, T. A. Mayo, H. Falk (three-quarters), A. Hawkins, J. C. Thomas (half-backs), H. M. Cruddas, A. J. W. Wells, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, A. Ll. Vaughan, F. H. Noke, F. Weber (forwards).

ST. BART'S HOSPITAL v. WICKHAM PARK.

Played at Winchmore Hill on January 9th. Result, a win for us by 1 goal to 1 try. The ground was in very bad condition, a part of it being under water; this rendered three-quarter play impossible. All through the game was of a scrambling nature. In the first half Wickham Park scored a try, which was not converted. On crossing over, Bart.'s played up, and Robbs, with a good dribble, scored. Randolph kicked a splendid goal. Nothing further was scored, so Bart.'s won by 5 points to 3 points.

Team.—T. A. Mayo (back), H. Falk, S. Mason, C. Dix, W. H. Randolph, G. C. Marrack, A. Hawkins (half-backs), H. M. Cruddas, A. J. W. Wells, J. K. S. Fleming, W. F. Bennett, C. H. D. Robbs, M. B. Scott, A. Ll. Vaughan, H. Weeks (forwards).

ST. BART'S HOSPITAL v. LENNOX.

Played at Winchmore Hill on January 16th. Bennett kicked off for Bart.'s, and the game was mostly confined to the forwards, the three-quarters not having much chance. Lennox were the first to score, the try being converted. Soon afterwards Mason, following up his own kick, scored a try, Randolph converting. Lennox scored again, the try being unconverted; but although Bart.'s played up well we were unable to equalise, the result being a defeat for Bart.'s by 8 points to 5 points.

Team.—T. M. Body (back), H. Falk, S. Mason, C. Dix, T. A. Mayo, A. Hawkins, W. H. Randolph (half-backs), H. M. Cruddas, A. J. W. Wells, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, H. C. Adams, M. B. Scott, A. M. Amsler.

Owing to the frost our fixtures with Upper Clapton and the Harlequins were scratched.

ST. BART'S HOSPITAL v. MARLBOROUGH NOMADS.

Played at Winchmore Hill on February 13th, and resulted in a defeat for us by 1 goal 2 tries to 1 goal. In this match Bart.'s forwards seemed to be utterly demoralised, the only redeeming point being a good piece of passing between Fleming and Robbs, which resulted in the latter gaining a try, which Randolph converted.

Team.—T. M. Body, H. Falk, T. A. Mayo, C. Dix, S. Mason (three-quarters), A. Hawkins, W. H. Randolph (half-backs), H. M. Cruddas, A. J. W. Wells, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, H. C. Adams, A. Ll. Vaughan, M. B. Scott (forwards).

ST. BART'S HOSPITAL v. EAST SHEEN.

Played at Richmond on Wednesday, February 17th. East Sheen had a very strong team against us, but Bart.'s played well together, and were only beaten by 22 points to 14. In the first half Falk made a brilliant run, and scored right between the posts. The try was not converted. East Sheen scored once, the try being converted, and also dropped a goal. In the second half Mason intercepted a pass in our "25," and made a brilliant run the whole length of the ground, and scored. The try was not converted. The same player also scored another try, which Randolph converted. Fleming, after a good dribble, scored a fourth try for Bart.'s, which was not converted; and so the game ended in a defeat for Bart.'s by 3 goals 1 try and 1 dropped goal to 1 goal and 3 tries.

Team.—C. Dix, S. Mason, T. A. Mayo, G. C. Marrack, H. Falk, A. Hawkins, W. H. Randolph (half-backs), H. M. Cruddas, A. J. W. Wells, W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, A. M. Amsler, A. Ll. Vaughan, J. M. Plews (forwards).

ST. BART'S HOSPITAL v. KING'S.

Played on Tuesday, February 9th. The result was a win for Bart.'s by 5 goals (1 dropped) to nil. Cruddas won the toss, and elected to play with the slight wind then prevailing. King's started the ball, and the kick was well returned. Scrums became the order of the game for a short time, in which Bart.'s had the advantage; the King's men, however, being quick with their feet, and especially at "picking up." Cox played a splendid and plucky game for King's at half. After about twenty minutes' play Hawkins dropped a neat goal for Bart.'s; soon after this the same player ran over the line and scored; this try was converted by Randolph, who must be congratulated on his place kicking. He also converted three other tries obtained by Hawkins, Cruddas, and Mason. The second half was similar to the first, scrums in which one side and then the other held the upper hand. When the ball was passed out to the three-quarters they invariably gained ground, at times passing the ball well from one side of the field to the other. Mason scored a grand try, running from our "25" line in fine style. King's played a much better game than the score would indicate. H. N. Clarke (Guy's) referee. Taylor (King's) and Hawes (Bart.'s) linesmen.

Team.—T. M. Body (back), S. Mason, C. Dix, T. A. Mayo, H. Falk (three-quarters), A. Hawkins, W. H. Randolph (half-backs), H. M. Cruddas (capt.), W. F. Bennett, J. K. S. Fleming, C. H. D. Robbs, H. C. Adams, A. Ll. Vaughan, M. B. Scott, A. M. Amsler (forwards).

INTER-HOSPITAL CUP.

First Round.—Charing Cross scratched to St. Bart.'s.

Guy's beat Middlesex, 3 goals and 2 tries to nil.

Second Round.—Guy's beat St. George's, 2 goals and 2 tries to nil.

St. Bartholomew's beat King's, 5 goals (1 penalty) to nil.

St. Thomas's beat London, 1 goal and 3 tries to nil.

St. Mary's beat Westminster, 7 goals and 4 tries to nil.

Semi-Final.—St. Bartholomew's v. Guy's (to be played Tuesday, February 23rd).

St. Thomas's v. St. Mary's.

ASSOCIATION FOOTBALL CLUB.

RESULTS OF MATCHES.

Jan. 9	... v. Sittingbourne	... at Sittingbourne	... lost ...	1-6
Jan. 13	... v. Old Reptonians	... at Winchmore Hill	... won ...	5-3
Jan. 16	... v. *Barnes Incogniti	... at Barnes	... lost ...	2-4
Feb. 3	... v. *Proprietary Sch.	... at Ealing	... won ...	5-3
Feb. 6	... v. *Ealing Reserves	... at Ealing	... won ...	3-2

* Reserves.

ST. BART'S HOSPITAL v. SITTINGBOURNE.

Played at Sittingbourne on January 9th. Bart.'s were very weakly represented, especially forward. Brown won the toss, and the Hospital played down the slope in the first half. From the kick-off Sittingbourne immediately began to press, and soon scored a couple of goals. Owing to the weakness of the forwards the backs could not be relieved, and before long Sittingbourne were leading by 4-0. At length the forwards managed to get away, and Bostock scored our only goal. After the interval there was a slight improvement, but the Hospital failed to increase their score, whilst Sittingbourne added 2, thus winning by 6-1.

Team.—J. M. Langton (goal); R. P. Brown, L. E. Whitaker (backs); M. G. Winder, D. S. Gerrish, H. J. Pickering (half-backs); L. E. Hughes, E. Wethered (right); E. W. Woodbridge (centre); A. H. Bostock, H. N. Marrett (left).

ST. BART'S HOSPITAL v. OLD REPTONIANS.

Played at Winchmore Hill on January 13th. In the first half Bart.'s played towards the pavilion, and did most of the pressing. Robinson and Willett each scored in the first twenty minutes, then Old Reptonians made several attacks on our goal, and finally scored with a good shot. Robinson soon scored again for the Hospital, and at half-time the score was 3-1 in favour of Bart.'s. After half-time the Hospital team took matters rather easily, and though at first they continued to press, and Willett scored twice, towards the end Old Reptonians got the best of the exchanges. Before time was called Old Reptonians added 2 goals, and the game ended in a win for Bart.'s by 5-3.

Team.—W. C. F. Harland (goal); L. Orton, L. E. Whitaker (backs); A. H. Bostock, D. S. Gerrish, H. J. Pickering (half-backs); T. H. Talbot, C. A. Robinson, J. A. Willett, E. W. Woodbridge, and H. N. Marrett (forwards).

LONDON CUP TIE.

ST. BART'S HOSPITAL v. OLD CARTHUSIANS.

This tie was played on Wednesday, February 17th, at Leyton, after being postponed from January 23rd. The Hospital were unfortunately unable to play full strength, Robinson and Gerrish being the absentees, their places, however, being well filled by Stone and Orton. During the first half Bart.'s held their own, though the Old Boys had somewhat the best of the exchanges, being baffled, however, at the goal by Fox. Smith scored for our opponents after twenty minutes' play, after a scramble in front of goal. Stone retaliated shortly after with an excellent long shot amidst loud applause, leaving the score at half-time one goal all.

In the second half the superior skill and pace of the opponents' forwards began to tell, and Fox was kept very busy effecting some marvellous saves, much to the delight of the spectators. The ground was heavy, and our men seemed to show signs of fatigue, for G. O. Smith, who had hitherto been effectually shadowed by Pickering, now became very dangerous, and added another point soon after half-time, while Wreford-Brown and Buzzard followed suit during the last half-hour, the game thus ending in our defeat by 4 goals to 1.

The Hospital are to be congratulated on making such a good game with so powerful a combination, in spite of their not being in full strength. Fox was brilliant in goal, and averted a heavy defeat. Whitaker was the best back on the field, and Pickering, as usual, indefatigable, time after time checking Smith in his attempts to get through. The forwards worked very hard, and the insides were well together, Stone, perhaps, being the most conspicuous.

TEAMS.

St. Bart.'s.—E. H. B. Fox (goal); R. P. Brown, L. E. Whitaker (backs); L. Orton, H. J. Pickering, A. H. Bostock (half-backs); T. H. Talbot, G. W. Stone (right wing), J. A. Willett (centre); E. W. Woodbridge, H. N. Marrett (left wing).

Old Carthusians.—J. T. McGaw (goal); E. C. Bliss, E. Garnett (backs); C. B. Ward, C. Wreford-Brown, F. L. Fane (half-backs); F. R. Barwell, E. F. Buzzard (right wing); G. O. Smith (centre); C. D. Hewitt, E. M. Tringham (left wing), (forwards).

INTER-HOSPITAL CUP.

First Round.—Charing Cross scratched to St. Bartholomew's.

Middlesex scratched to St. Mary's.

University scratched to Guy's.

London beat St. Thomas's, 4 goals to 3.

Semi-Final.—St. Bartholomew's v. Guy's (to be played on Wednesday, March 3rd).

St. Mary's v. London.

UNITED HOSPITAL HARE AND HOUNDS.

THE annual inter-hospital contest will take place on Saturday, February 27th.

Abernethian Society.

At a meeting of the Society on Thursday, January 21st, Mr. W. T. Holmes Spicer, ex-President, read a paper on "Eye Symptoms in General Diseases," in which he emphasised the great help to be derived from the ophthalmoscope for diagnostic purposes. In addition to an interesting *résumé* of various eye symptoms in many diseases, the reader of the paper claimed that the Argyll-Robertson pupil is always a sign of old syphilis, and doubted whether so-called rheumatic iritis was really of rheumatic origin. It is never seen in acute rheumatism, and he was inclined to attribute it to gonorrhœa. A short discussion followed.

Dr. Claye Shaw is always willing to show his interest in the Society in a practical form, and few communications are more anticipated than his. Consequently there was a good attendance of members to welcome his arrival on January 28th. Dr. Shaw discoursed in his usual delightful fashion on things in general, and on "Wounds and Bruises in the Insane" in particular. The paper will appear in these pages at an early date.

The meeting of February 4th took place under the disadvantage of most inclement weather. Mr. Pigg showed a heart with numerous hæmorrhages, prepared by the formalin method from a case of hæmophilia. Mr. R. Bremridge then read his paper on "Some Affections of the Vaso-motor System." After an abstract of the recent researches of Leonard Hill and Oliver on the effect of gravity on the circulation, and the compensation thereof effected by the vaso-motor system, he went on to show the exceedingly important practical bearing these theoretical considerations had upon the treatment of various conditions. He also put forward an ingenious theory as to the cause of post-influenzal neurasthenia, and its rational treatment by vaso-constrictors.

At a meeting of the Society on February 11th a case of syringomyelia with painless whitlows was shown by Mr. Bremridge. Mr. T. J. Horder then read his paper on "Glycosuria." He pointed out that the problem of glycosuria lay at the basis of any inquiry into carbohydrate metabolism. He gave an interesting abstract of the history of our knowledge of the disease, and stated the results of a series of observations conducted by himself on the effects of drugs on glycosuria. His conclusion on an exhaustive survey of the subject was that diabetes as a disease had no separate entity apart from its chief symptom, glycosuria.

The hon. secretaries beg to acknowledge with many thanks the receipt of a copy of an Abernethian Address from Mr.

R. Henslowe-Wellington, of Sutton Bridge. This address was delivered in 1876 by Mr. Benton, on "Nurses and Nursing," in which he advocated a system of things regarded to-day as the only possible. At the time of its utterance, however, it could have been little short of revolutionary, so far have we advanced since then. The secretaries venture to renew their appeal to old members for copies of Abernethian pamphlets, a complete series of which would form an interesting and most valuable collection.

The Rahere Lodge, No. 2546.

A MEETING of the Rahere Lodge was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, February 9th, 1897; Bro. Alfred Cooper, F.R.C.S.Eng., in the Chair. Bros. Horton-Smith, Owen Lankester, Laming Evans, Gow, and Sloane were admitted to the third degree in Freemasonry. Bro. Worthington was passed to the second degree, and Mr. Howard Marshall was initiated into masonry. The brethren afterwards dined together. A sum of ten guineas was voted to the Royal Medical Benevolent College, and one guinea to the Guy's Hospital Re-endowment Fund.

Cases of Special Interest.

Rahere, bed 11.—Multiple sarcoma.
 Rahere, bed 15.—Exophthalmic goitre.
 Colston, bed 19.—Anæmia.
 Colston, bed 15.—Abdominal growth.
 Colston, bed 6.—Chronic dysentery.
 Matthew, bed 24.—Nephritis.
 Matthew, bed 2.—Gout.
 Luke, bed 10.—Paralysis.
 Luke, bed 23.—Hemiplegia with epileptoid fits.
 Mark, bed 13.—Central tumour.
 Mark, bed 14.—Enlarged glands.
 Faith, bed 3.—Raynaud's disease.
 Faith, bed 5.—Optic atrophy with anæmia.
 Faith, bed 10.—Alcoholic neuritis.
 Faith, bed 11.—Splenic anæmia.
 Hope, bed 3.—Hemiplegia after typhoid.
 Hope, bed 4.—Heart disease, ? congenital.
 Hope, bed 18.—Pseudo-membranous bronchitis.
 John, bed 10.—Heart disease, ? congenital.
 John, bed 18.—Bulbar paralysis.
 John, bed 20.—Alcoholic neuritis.

Congenital Abnormality of Ureter with Absence of Kidney.

By C. HAMILTON WHITEFORD, M.R.C.S., L.R.C.P.

FROM a patient æt. 65, who died of uræmia, the right kidney and ureter being distended with purulent urine, the bladder hypertrophied and sacculated. The bladder, ureters, and kidney were dissected out *en masse*. The left kidney was represented by a small fibrous mass, in size equal to half a chestnut. From this mass the left ureter, very thin-walled, and

distended to double its normal size by thin turbid yellow fluid, terminated in the highest part of the left seminal vesicle. There was no continuation of ureter to the bladder, nor was there any suggestion of an opening to be found on examination from within the bladder. The left supra-renal was normal. Mr. Lockwood, who has kindly examined the specimen, considers the abnormality a congenital one. There are two similar specimens in the Hospital museum. He says, "The ureter and the vesicula are both outgrowths from the lower end of the vas, or Wolffian duct, as it is there called. In this case the kidney duct has protruded from the vas in conjunction with the vesicula." The importance of ascertaining, prior to nephrectomy, the presence of a second kidney, with the further question of the second kidney being in working order, is well demonstrated by this case.

Appointments.

MITCHELL, A. M., M.B., B.C.Cantab., has been appointed Resident Medical Officer to Queen Charlotte's Lying-in Hospital, London.

POWELL, H. A., M.D., M.Ch.Oxon., L.R.C.P.Lond., M.R.C.S., F.R.C.S.Edin., has been appointed an Honorary Surgeon to the Royal Hants County Hospital.

PULLIN, B. GIBBES, L.R.C.P.Lond., M.R.C.S., L.S.A., has been appointed a surgeon to the Sidmouth Cottage Hospital.

GALE, F. W., M.R.C.S., L.R.C.P., L.S.A., has been appointed Public Vaccinator and Native Medical Officer for the Kaikoura District, New Zealand.

MORRISON, J., M.D.Lond., M.R.C.S., L.R.C.P., appointed Physician to the Farringdon General Dispensary.

CHRISTOPHERSON, J. B., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Evelina Hospital for Children.

POYNTER, F. C., M.B., B.Ch.Oxon., M.R.C.S., L.R.C.P., appointed House Surgeon to the West London Hospital.

BROCK, J., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Beckett Hospital, Barnsley.

STEPHENS, J. W. W., M.B., B.C.Cantab., appointed Assistant Bacteriologist to the Government in India.

EVANS, HERBERT, M.B.Oxon., M.R.C.S.Eng., appointed *pro tem*. Medical Officer of Health to the Seaford Urban Sanitary District.

ISACKE, MATTHEW WM. STUART, M.R.C.S., L.R.C.P.Lond., appointed Third Assistant Medical Officer to the Wadley Asylum of the West Riding County Council.

WOOD, T. OUTTERSON, M.D., F.R.C.P.Edin., M.R.C.P.Lond., appointed Consulting Physician to the St. George's and St. James's Dispensary, King Street, Regent Street, W.

Examinations.

FINAL M.R.C.S. AND L.R.C.P.—The following having passed all parts of the final examination have been admitted to the diplomas of M.R.C.S. and L.R.C.P., viz.:—G. E. Dodson, R. S. C. Edleston, R. R. Thomas, J. B. Hughes, H. C. T. Langdon, W. J. Harding, C. C. Grummitt, J. H. Wood, R. H. Bremridge, N. H. Harris, W. H. F. Oxley, N. Buendia, R. E. W. Jennings, W. J. Richards, H. G. Berry, W. F. Evans, S. Roach, J. Torrance, G. S. Haynes.

D.P.H. CONJOINT BOARD.—W. B. Jones, H. T. Parker, and J. S. Richards have taken this diploma.

PRELIMINARY SCIENCE, LONDON UNIVERSITY.—*Entire Examination*.—V. G. Ward. *Chemistry and Physics*.—H. A. Kellond-Knight, H. H. Raw, R. A. S. Sunderland, A. E. Thomas, E. S. Ellis, and F. H. Wood. *Ecology*.—S. W. Milner, and F. H. Noke.

CONJOINT BOARD: FIVE YEARS' REGULATIONS.—*Chemistry and Physics*.—A. M. Dalzell, S. de Carteret, A. B. Edwards, C. Fisher, A. L. B. Green, R. J. Hanbury, H. W. Pank, J. C. Sale, R. Thompson, J. H. West, H. Whitwell. *Practical Pharmacy*.—H. C. Adams, R. Bigg, E. S. E. Hewer, N. H. Joy, J. L. Morris, E. F. Palgrave, A. B. Pugh. *Elementary Biology*.—C. Dix, T. H. Fowler, H. P. Margetts, J. K. N. Marsh, J. C. Sale, A. E. Soden. *Anatomy and Physiology*.—T. W. Brown, H. Burrows, W. P. Dyer, H. W. Illius, J. W. Illius, G. J. A. Leclezio, J. O'Hea, G. H. Orton, R. Walker.

FOUR YEARS' REGULATIONS.—*Chemistry and Physics*.—F. R. Dudley. *Materia Medica*.—V. S. A. Bell. *Anatomy*.—E. F. Crabtree. *Physiology*.—W. M. James.

M.B. OXFORD.—J. C. Fisher, A. L. Ormerod.

INTERMEDIATE M.B. LONDON.—*Entire Examination: First Division*.—F. C. Borrow. *Excluding Physiology: Second Division*.—C. R. Brown, H. Burrows, W. H. Cazaly, J. M. Collyns, W. S. Danks, E. P. H. Dudley, C. S. Frost, T. H. Gandy, J. S. Gayner, J. G. F. Hosken, S. A. Millen, A. J. W. Wells. *Physiology only: Second Division*.—H. D. Everington, R. Hatfield, H. A. Schöberg, S. R. Scott, L. A. Walker.

F.R.C.S. EDINBURGH.—A. H. Buck.

SOCIETY OF APOTHECARIES.—*Surgery*.—E. C. Corfield, F. Harvey. *Medicine, Forensic Medicine, and Midwifery*.—F. Harvey.

Obituary.

DR. JAMES ELLISON.

DR. JAMES ELLISON, surgeon and apothecary to Her Majesty's household at Windsor, died on January 31st last. He was in his eightieth year, having been born in India in 1817. He was essentially a practitioner of the old school, but was a well-educated and accomplished man, being not only an excellent linguist and clever artist, but also accomplished in sport and games of skill. He began his medical education, under the former apprenticeship system, as a pupil of Mr. Walker, of Peterborough, in 1834. After five years of pupilage under Mr. Walker, whose daughter he subsequently married in 1847, he entered as a student of St. Bartholomew's, and after a successful and distinguished career he qualified as M.R.C.S. and L.S.A. He then became House Surgeon to the Peterborough Infirmary, and subsequently studied for a time at Heidelberg, ultimately taking the M.D. degree of the University of London.

He then commenced practice in London, and subsequently went into partnership with Mr. H. Brown, of Windsor, then Surgeon Apothecary to Her Majesty's Household. In 1852, having settled at Windsor, he received his appointment to Her Majesty's household, which he held till the day of his death. He was highly popular and much respected in Windsor and the neighbourhood, taking interest in all local sports and games, and being at one time prominent in the Berkshire Regiment of Volunteers. The cause of death was malignant stricture of the œsophagus.

Correspondence.

To the Editor of St. Bartholomew's Hospital Journal.

INFANTILE DIARRHŒA.

DEAR SIR,—Will you allow me an opportunity of thanking Dr. Cautley for his paper on "Infantile Diarrhœa" in your current issue, more especially as a sequel to his most valuable paper on the "Artificial Rearing of Infants" in the number for October, 1895? which I have found of the greatest assistance, and have kept at hand

for constant reference. In his preface to the January paper Dr. Cautley urges the importance of the subject; this, I am sure, cannot be over-estimated. Both with one's poorer patients, and with the infants of the rich and the nurses in charge of them, the most constant supervision and the most minute attention to details are so essential that without these the children constantly go wrong. While appreciating Dr. Cautley's warning against the indiscriminate use of antiseptic drugs in infantile diarrhœa, and his insistence on improving the diet as a means to its relief, may I put in a plea, as an adjunct to improved food, for the value of, in some cases (generally the milder ones), small doses of Liq. Hydrarg. Perchlor.; in other cases (especially those with green stools and much flatulence) of small doses of salol every morning with a mixture containing soda, rhubarb, and peppermint during the day? I have found these drugs to hasten the improvement, and to give the improved diet a better chance, and in these cases time is of the utmost importance.

Yours faithfully,

LAURENCE A. WINTER.

Chartham, Canterbury;

January 31st, 1897.

To the Editor of St. Bartholomew's Hospital Journal.

SISTER MAGDALEN FUND.

	£	s.	d.
Amount already acknowledged ...	61	16	4
Dr. Lush (Weymouth) ...	0	10	6
Total ...	£62	6	10

EDGAR WILLETT.

Births.

GRAY.—On January 16th, at Wadham Lodge, Ealing, the wife of John Alfred Gray, M.B., of a son.

KENNINGTON.—On January 13th, at Burden Park, Tonbridge, the wife of Edgar Kennington, M.R.C.S., Wisbech, of a daughter.

STYAN.—On January 22nd, at 2, Chapel Place, Ramsgate, the wife of T. G. Styan, M.A., M.D. Cantab., of a son.

TAIT.—On January 27th, at 48, Highbury Park, the wife of Edward Sabine Tait, M.D., of a daughter.

Marriages.

ACKLAND—MACRORY.—On February 13th, at St. Stephen's Church, Westbourne Park, W., by the Rev. J. H. Ellison, M.A., Vicar of Windsor and Chaplain to the Queen, assisted by the Rev. J. Hallward, M.A., and the Rev. W. M. Snook, M.A., Robert Craig Ackland, M.R.C.S., L.R.C.P., third son of the late Robert Ackland, Esq., of Exeter, to Ruth Kathleen, youngest daughter of Edmund Macrory, O.C., of 19, Pembroke Square, W., and Duncan, co. Antrim, and granddaughter of the late Mr. Justice Manisty.

HENSLEY—LOW.—On February 24th, at the Priory Church, St. Bartholomew the Great, by the Rev. Sir Borodale Savory, Bart., Philip John Hensley, M.D., F.R.C.P., of 4, Henrietta Street, Cavendish Square, to Marie, eldest daughter of Maximilian Low, Esq., late of Park Road, Haverstock Hill. At home, Thursdays in May.

Deaths.

LLOYD-WILLIAMS.—On December 14th, 1896, at Vronheulog, Corwen Humphrey Lloyd-Williams, M.R.C.S., L.S.A., 51 years of age.

STOCKER.—On January 31st, at Weedon, Ethel Gwendolen, beloved daughter of Edward and Ethel Stocker, aged 3 years.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette*, *St. George's Hospital Gazette*, *St. Thomas's Hospital Gazette*, *St. Mary's Hospital Gazette*, *The Middlesex Hospital Journal*, *The Gynoscope*, *The Student (Edinburgh)*, *The Nursing Record*, *The Charity Record*, *The Hospital*.